# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO THE ARKANSAS INSURANCE DEPARTMENT

I,_____ authorize _____
(name of consumer) (name of insurer or other party)
to disclose the following health information to the employees of the Arkansas Insurance Department upon request:

_____
_____
_____
_____
(specific and meaningful description of the information to be provided)

This authorization is valid for 24 months from the date of signature, unless revoked. If I wish to revoke this authorization, I can do so by sending a written request to_____
(name of person handling complaint) at the Arkansas Insurance Department. I understand that I have the right to revoke this authorization in writing, unless_____
(name of covered entity)
has already taken action under the authorization.

Information received by the Arkansas Insurance Department may be subject to redisclosure by the Department and will not be protected by federal law. The Arkansas Insurance Department will not disclose your health information except as allowed by law.

_____
Signature of consumer (or personal representative of consumer, along with description of the representative's authority)

_____
Date

(10/01)